KPMG Peat Marwick Stevenson & Kellogg
Management Consultants

Project Report

FUTURE DIRECTIONS FOR ADDICTION SERVICES FOR WOMEN ON PRINCE EDWARD ISLAND

Prepared for

The Minister of
Health and Social Services

Halifax
April 5, 1991
1679/VAM/cmm

Contents

I Introduction 1

II Highlights 2

III The Continuum Of Need And Care 5

A. The distribution of the problem is significant in identifying where to direct the efforts 5

B. A continuum of care is essential 7

IV The Essential Elements 12

A. Flexibility is perhaps the most important characteristic 12

B. Treatment services must recognize the needs of special groups 12

C. Staffing mix and qualifications are also important 16

D. Programme evaluation is essential 17

V Addiction Services In Other Provinces 18

A. Alcohol and drug dependency services in New Brunswick 18

B. Alcohol and drug dependency services in Nova Scotia 21

C. Alcohol and drug dependency services in Newfoundland and Labrador 27

D. Other jurisdictions 29

91-05337/

Contents—Con't

VI Addiction Services On PEI 30

A. Historical background 30

B. Structure and organization of Addiction Services of Prince Edward Island 31

C. Addiction Services of Prince Edward Island—programmes and services 32

D. Mann House 42

E. Other services support women with chemical dependencies 47

VII Addiction Services For Women—Issues And Recommendations 49

A. Staffing 49

B. Membership of the Provincial Advisory Committee should be broadened 51

C. Quality and outcome monitoring should be further developed 52

D. Public education must continue 53

E. Addiction Services should assist other providers to recognize and refer persons with chemical dependencies 53

F. Programmes and services should meet women's needs 54

G. Summary 59

Appendices 61

A. Footnotes 62

B. List of organizations interviewed 65

I

Introduction

This report presents the results of our study of addiction services for women on Prince Edward Island.

Addiction services for both men and women in the province are delivered through three county agencies that provide treatment and prevention through a range of residential and non-residential services. In addition, Mann House, an independent agency, offered a residential programme for women until late 1990.

Questions raised concerning the closure of Mann House led the provincial government to engage Peat Marwick Stevenson & Kellogg to examine all aspects of services for chemically dependent women on PEI. The goal of the review was to advise government on whether the current method of providing services to women is the most appropriate or whether some other system, including the possibility of reinstating funding for Mann House, should be considered. In carrying out our work, we have benefitted from the full support of many persons and agencies. A list of organizations interviewed is included in Appendix B.

We have used a number of terms for chemical dependencies in the report. Terms include "alcohol problems", "chemical dependency", "addiction" and "substance abuse." All these terms are intended to refer to dependence on either drugs, or alcohol, or both and refer to the population in need.

II

Highlights

Until midway into the twentieth century society regarded addictions as a moral, rather than a medical matter. However, in the mid-1960's international authorities began to recognize alcoholism as a disease requiring treatment rather than a form of social deviance. As with most medical services, treatment initially focussed on the most severe problems. The continuum of care that developed throughout North America to address these needs has been divided into three phases—detoxification, treatment and aftercare.

In recent years, addiction services providers have increasingly recognized that alcohol problems can range from none through a spectrum of mild, moderate and substantial to severe. To address the spectrum of need of persons at risk in each category requires provision of a continuum of care focussed on meeting each individual's needs. This continuum should be expanded beyond the specialized treatment identified previously to include primary prevention and brief intervention.

On Prince Edward Island, and throughout North America, a variety of programmes and services within the broader continuum of care have developed. While most resources continue to be directed at specialized treatment, primary prevention and brief intervention services such as family programmes, community development programmes, Alateen and others have attempted to address at least a portion of the previously undeveloped components of the continuum of care.

Throughout North America the majority of patients seeking treatment for addictions have traditionally been male. Hence the body of knowledge for treatment has largely been based on male needs. As more women present for treatment and providers evaluate outcomes of their interventions, the special needs of women are becoming better recognized. In recent years, many providers have begun to explore ways of meeting these special needs.

Perhaps the single most important factor now recognized in successfully treating both men and women is flexibility. Within a flexible framework, some of the components requiring special attention for women include:

- Availability of female counsellors and counsellors specifically trained in meeting the needs of women.
- Child care and child treatment.
- Linkages with women's organizations.
- Choices of integrated or segregated treatment and aftercare groups.
- Sensitivity to the needs of victims of abuse.

These services can be offered in a variety of inpatient and outpatient settings.

Some jurisdictions are attempting to address these needs within existing structures. For example, the Nova Scotia Commission on Drug Dependency offers a "women's only" rehabilitation programme in Sydney that can be attended on either an inpatient or outpatient basis. Others, such as the Amethyst Treatment Programme in Ottawa offering a day treatment programme for women, developed as independent agencies.

In 1986, Mann House, a privately operated 10-bed extended care facility for women opened in Charlottetown as a demonstration project. Its purpose was to meet the needs of chemically dependent women requiring extended care to permit effective reentry to society. A combination of government and private funding supported this facility until late 1990.

Government had previously directed that Mann House be incorportated into the services of Queens County Addiction Service (QCAS). When QCAS and Mann House were unable to reach agreement on how this would occur, government funding of Mann House ceased. Government then requested QCAS to expand its role and provide extended care services for women.

We were asked to evaluate the appropriateness of this decision. We interviewed a number of persons on PEI involved in women's addiction services, reviewed relevant documentation and sought input from providers outside PEI. We identified strengths and weaknesses in the services of both Mann House and the three county agencies. We found that cooperation between service providers was lacking. And we have concerns about cost effectiveness. Given the population and resources of the province of PEI it is essential that all providers of women's addiction services work together to provide an effective, efficient continuum of care. We therefore do not recommend reinstatement of government funding to Mann House. Continuing many of the Mann House programmes through the existing county agencies and redirecting the funds to these agencies will provide the most cost effective treatment system.

Prince Edward Island is richly endowed with treatment services for persons with addictions. In fact, the ratio of treatment beds per thousand population of PEI is three times that of the other three Atlantic provinces. Outpatient services are also available in the three counties. However, these services have been less successful than in other Atlantic provinces in increasing the number of women treated. This suggests a need for PEI to redirect some of its existing resources to focus on the special needs of women. In particular, an emphasis on flexible outpatient programming with staff specially trained in meeting the needs of women should be developed. Specific initiatives we recommend to enhance services to chemically dependent women throughout PEI include:

- Enhance staffing in addiction services to include more female counsellors, more professionally trained counsellors, and counsellors specifically trained to recognize and deal with the special needs of women.

- Develop a pilot non-residential comprehensive rehabilitation programme for women.

- Provide separate women's aftercare groups.

- Enhance linkages between Addiction Services and related community agencies for the purposes of staff education, client programme delivery and earlier identification.

- Appoint a multi-agency task force to explore, in detail, the child care needs of women in need of treatment for chemical dependency.

- Develop formal quality assurance programmes within each county agency.

- Develop formalized programme planning and evaluation of all addiction services.

- Broaden the membership of the Provincial Advisory Committee to include an individual with knowledge of the special needs of women with chemical dependencies.

III

The Continuum Of Need And Care

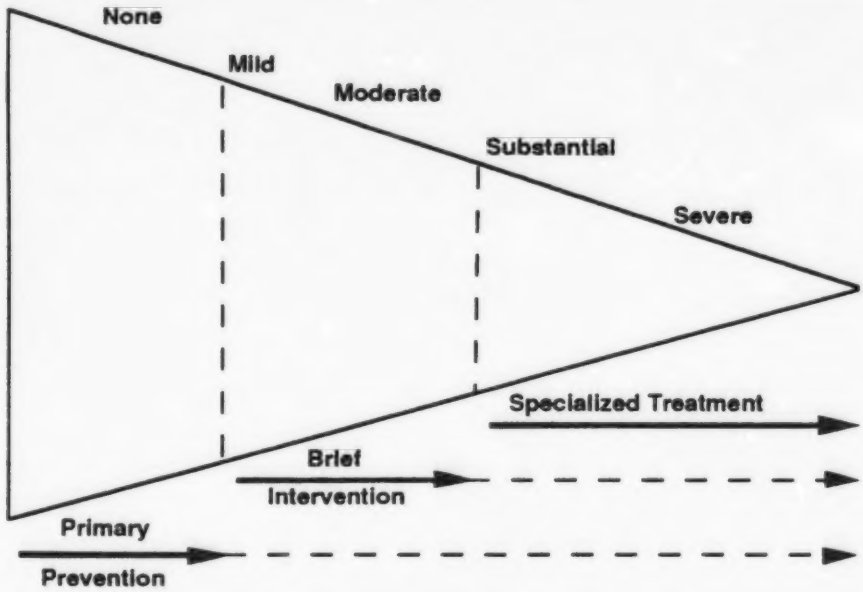
This chapter provides an overview of the problems associated with alcohol use in the general population and the continuum of services needed to address these problems. It provides the framework for our analysis of services on PEI that follows in subsequent chapters.

In preparing this overview, we have drawn heavily on a recently published (1990) book entitled Broadening the Base of Treatment for Alcohol Problems. This text was written by an expert committee of the Institute of Medicine in the United States. It represents a synthesis of current knowledge in the field of alcohol and other addictions and pays particular attention to the importance of developing therapeutic approaches that are sensitive to the special and diverse needs of persons having problems with alcohol use.

A. The distribution of the problem is significant in identifying where to direct the efforts

In Broadening the Base of Treatment for Alcohol Problems, the authors identify a number of important premises upon which their discussion is based. Of particular relevance to the issue of defining the continuum of need is their premise that "...the target population for treatment comprises all who experience or who are likely to experience any sort of problem arising in connection with their use of beverage alcohol." (Institute of Medicine, 1990, p. 211). Based on this premise, they used a diagram (Exhibit III-1) to categorize the spectrum of alcohol problems in the population and the interventions that can be applied to each segment. (Institute of Medicine, 1990, p. 212)

Exhibit III-1
Alcohol problems in the population



The triangle represents the population of the United States, with the range of alcohol problems experienced indicated above. Responses to each of the problems are shown along the lower side. The extension of the primary prevention and brief intervention arrows indicates that these interventions will also have important effects on persons who have developed problems more severe than those in the target population for which these interventions are most effective.

Based on this model, the largest portion of the population experiences no alcohol problems. However, within this group are persons who are at risk of developing problems due to such factors as a family history of alcohol problems or other problems. Hence, primary prevention efforts are aimed at those who are not engaged in risky or problematic drinking but who may be at risk.

The population represented by the middle portion of the triangle experiences mild to moderate alcohol problems. Secondary prevention, or brief intervention activities are directed at this group to reduce or eliminate alcohol consumption quickly and efficiently to prevent the consequences of consumption.

The apex of the triangle represents the population of heavy drinkers who experience multiple consequences of their drinking. Although heavy drinkers comprise only a relatively small portion of the population, the majority of efforts to deal with alcohol problems have been focused on this group. (Institute of Medicine, 1990, p. 211-213). As pointed out in Broadening The Base Of Treatment For Alcohol Problems, however, "If the alcohol problems experienced by the population are to be reduced significantly, the distribution of these problems in the population suggests that a principal focus of interventions should be on persons with mild or moderate alcohol problems". (Institute of Medicine, 1990, p. 215)

B. A continuum of care is essential

Historically, the continuum of care for chemical dependencies has been divided into three phases—detoxification, treatment and aftercare. However, these phases focus only on the portion of the target population with the most severe problems. As such, a more appropriate categorization of the continuum of care includes "...a spectrum of interventions that match the spectrum of alcohol problems." (Institute of Medicine, 1990, p. 218) Within this context, the following broad definition of treatment should be used as the basis for future planning of services for those with chemical dependencies on PEI.

"Treatment refers to the broad range of services, including identification, brief intervention, assessment, diagnosis, counselling, medical services, psychiatric services, psychological services, social services and follow-up, for persons with alcohol problems. The overall goal of treatment is to reduce or eliminate the use of alcohol as a contributing factor to physical, psychological and social dysfunction and to arrest, retard, or reverse the progress of any associated problems". (Institute of Medicine, 1990, p. 46)

This is not to suggest that the specialized treatment sector should be the provider of all services. On the contrary, many other organizations and agencies currently provide important intervention programmes that offer referral, education and counselling services. These include employee assistance programmes, drinking driver programmes, social service agencies, mental health counselling services, hospitals, schools and others. These and other such organizations should be considered as essential elements of the continuum of care.

1. Community-based services

The authors of Broadening The Base Of Treatment For Alcohol Problems, consider community organizations and agencies outside the specialized treatment sector to be the most appropriate providers of identification, brief intervention and brief therapy services.

a) Identification

Identification involves determining whether an individual has an alcohol problem of any degree that requires treatment. Two major methods of identifying these problems are laboratory examination of body fluids and questions or questionnaires. The first of these methods has a number of limitations including cost, difficulty in using outside a medical setting and lack of sensitivity—that is, these tests are likely to miss a large number of cases.

Questions and questionnaires are less expensive and do not require a high level of professional expertise to administer. Many of the tools that have been developed, however, were designed specifically to identify persons with severe alcohol problems. Given the acceptance of a much broader definition of the target population, we believe that use of a tool such as the AUDIT is more appropriate. This tool was developed cross-nationally in six countries using large samples. Its ten items are simple and can be administered by non-

technical staff or self-administered. The tool covers alcohol consumption, symptoms of alcohol use, and its consequences—three areas of content that are desirable for a full description of the problem. (Institute of Medicine, 1990, p. 218-219)

Before leaving the discussion of identification, it should be noted that

"Most case-finding and referral systems in drug dependence treatment programmes are designed for male clients. The primary sources of referrals in a great many programmes are from the criminal justice system, (for drunk driving, or disorderly or criminal behaviour), physicians, employee assistance programmes and as a result of pressure from family members. All of these are less effective for women." (Reed, 1987, p. 160)

The reasons for this include:

- Women are less involved in behaviours that would lead to involvement in criminal behaviour.
- Women frequently occupy jobs that are of less concern to employers.
- While women tend to visit health care providers more frequently than men, health care professionals are far less likely to recognize chemical dependency in women than men or to refer women for treatment.
- Many families oppose treatment because it is disruptive and hence are less likely to refer. (Reed, 1987, p. 160)

These problems in case-finding for women strongly suggest that training programmes for employers, personnel in the health care, social service, family, mental health and justice systems are needed to improve the rate of referral of women from these sectors.

b) Brief intervention

Brief intervention is a form of triage, aimed at those with mild or moderate problems who can be dealt with in the community setting by staff trained in delivering these services. Brief intervention can take a variety of forms including:

- Persuasion to reduce alcohol consumption.
- Informing individuals that their level of alcohol consumption is above acceptable, safe or usual levels for a comparable population.
- Identification of the harmful effects of continued use of alcohol.
- Feedback on lab tests.
- Providing clients with a means of objectively and regularly recording alcohol consumption.

Brief intervention "packages" can be delivered by a variety of individuals with only modest training. Similarly, brief intervention takes only a few minutes to an hour and at most only one additional session. These factors make brief intervention highly attractive when funds are limited. (Institute of Medicine, 1990, p. 225)

Several studies of brief intervention suggest that it is quite effective for some persons. As the authors of Broadening the Base of Treatment for Alcohol Problems note, "It appears that a variety of techniques can be deployed in different settings by various kinds of personnel without disrupting the usual flow of activities and that such techniques can produce significant and health-relevant effects".(Institute of Medicine, 1990, p.225)

c) Brief therapy

Brief therapy can also be provided by agencies outside the specialized treatment sector, although it does require more highly skilled staff and a longer duration of contact.

"Brief therapy involves instructing clients in specific behavioural methods for reaching abstinence or moderate drinking (i.e. goal setting, self-monitoring, identification of "high risk" situations, and instruction in procedures for avoiding drinking or over-drinking). Usually brief therapy is preceded by a comprehensive assessment and does not exceed six sessions of outpatient counselling". (Institute of Medicine, 1990, p. 225)

While this form of intervention is not the first choice for those with moderate to severe problems, persons in this category who refuse specialized treatment may be willing to follow through with brief therapy. And, while the success rate will not be as high for this group, failure of this form of therapy may persuade some individuals to seek special treatment.

d) Referral

Referral is the final element of the community role. When persons are identified with problems too severe to manage through brief intervention or brief therapy, the community agency should refer the client to the specialized treatment sector for assessment and treatment.

2. Services provided by the specialized treatment sector

Many authors have attempted to categorize the stages of treatment that should be provided by the specialized treatment sector. The authors of Broadening The Base have synthesized the works of a variety of authors and developed a framework that includes three stages of treatment and four settings in which it is provided.

a) Acute intervention (Stage 1)

Acute intervention includes:

- Emergency treatment to resolve acute physical, social, or psychological emergencies due to excessive alcohol intake.

- Detoxification.

- Screening to identify the existence of a problem, followed by referral as appropriate.

Hence, this stage includes treatment for those with severe problems, as well as screening for those in the community who may have a problem.

b) Rehabilitation (Stage 2)

Rehabilitation includes:

- Evaluation and assessment in order to develop an individualized treatment plan. This will include assessment of physical, psychological and social status, and identification of environmental factors that led to the drinking problem.

- Primary care, or the application of therapeutic activities to improve physical, psychological and social functioning while in an independent or sheltered living environment. (This can include brief intervention activities, as well as intensive intervention.)

- Extended care, or stabilization through consolidation of gains achieved in primary care by participation in treatment and supportive activities in a variety of living situations.

c) Maintenance (Stage 3)

Maintenance includes:

- Aftercare (or continuing care) through continued provision of therapeutic services to maintain improvement gained earlier in treatment while either in an independent, transitional, or long term sheltered living environment.

- Relapse prevention through therapeutic activities to prevent the return to prior drinking patterns and to maintain improvements achieved through earlier stages of treatment. These services are provided to persons in the same living environments mentioned above.

- Domiciliary care, or provision of ongoing support in a protected living environment for those too disabled by previous use of alcohol to live independently.

Further elaboration on aftercare is warranted here. In reviewing the literature, the authors of Broadening the Base of Treatment for Alcohol Problems (Institute of Medicine, 1990, p. 65-66) note that aftercare varies greatly in duration and format, with activities ranging from monthly telephone contacts to attendance at weekly counselling sessions. Aftercare may also refer to a halfway house, or referral to another agency. In the face of continued ambiguity surrounding aftercare, the authors note that many in the field have begun to use the concepts of continuing care, follow-up and relapse

prevention. We agree that those concepts are preferable to aftercare which implies that treatment ends with discharge from primary rehabilitation. (Institute of Medicine, 1990, p.60)

The services identified above can be provided in a variety of settings including:

- Inpatient - for those requiring 24 hour supervision in a hospital or similarly equipped setting.
- Residential - for those requiring 24 hour supervision in a free-standing residential setting.
- Intermediate - for those requiring care or support in a setting that provides less than a 24 hour treatment or recovery setting.
- Outpatient - for those who can benefit from treatment available through ambulatory care settings while living in their usual environment. (Institute of Medicine, 1990, p.72-73)

IV

The Essential Elements

In this chapter, we describe the essential elements and characteristics of a comprehensive system for treatment of persons with chemical dependencies. Particular emphasis is placed on factors important in the treatment of chemically dependent women. To supplement information found in Broadening the Base of Treatment for Alcohol Problems relative to treatment for women with dependencies, we have drawn upon Getting Sober, Getting Well: A Treatment Guide for Caregivers Who Work With Women. This guide was published by the Women's Alcohol Programme of the Cambridge-Somerville Alcoholism Programme (CASPAR). By 1989, this programme had treated over 6,000 women, including in recent years, a majority of women with co-dependencies.

A. Flexibility is perhaps the most important characteristic

While consensus has yet to be reached on many issues surrounding the management of chemical dependencies, from our review of the literature there appears to be agreement that while "there are many commonalities among different forms of drug dependence... there is no typical alcoholic." (Reed, 1987, p. 155) Hence, as the authors of Broadening the Base of Treatment for Alcohol Problems note, "treatment for alcohol problems includes a broad range of activities that vary in content, duration, intensity, goals, setting, provider and target population and no single treatment approach or modality has been demonstrated to be superior to all others". (Institute of Medicine, 1990, p. 86)

B. Treatment services must recognize the needs of special groups

Notwithstanding the above, much work has been done in identifying treatment options that are more likely to produce better outcomes for special groups, including women. Experience has shown that chemically dependent women differ from their male counterparts in many ways, but most importantly in the range and complexity of other problems they present with. Clinical data supported by several studies identify a number of areas in which females may differ from males, suggesting that programming needs would be different. These findings indicate that women are more likely to have:

- Primary affective disorders and depressed/sad mood states.
- Serious liver disease.
- Marital instability.
- Instability of family of origin.
- Spouses with alcohol problems.
- A history of sexual abuse.
- Opposition to treatment from family and friends.
- More child care responsibiilities. (Institute of Medicine, 1990, p. 357)

These apparent differences between women and men with alcohol problems provide insight into the programming needs of women. To be effective, treatment and follow-up services for women must address these problems. The elements of a comprehensive women's substance abuse programme identified in Getting Sober, Getting Well include:

1. Outreach

- Outreach workers to do substance abuse education and consultation with community agencies and organizations.
- Media work including radio, television and publication of materials on women and substance abuse for newspapers, magazines, books.
- Linkages with local women's organizations and human service agencies for training, consultation and information sharing.
- Training and consultation for substance abuse providers on women's issues.

2. Inpatient unit

- Women's detox or separate women's wing, warm home-like atmosphere.
- Women counsellors, women administrators.
- Women's discussion groups and individual counselling.
- Individual, group and family counselling.
- On-site as well as community child care services.

3. Residential programme

- All-women's house, homey atmosphere.
- Women counsellors, women administrators.
- Accommodations for women with their children.
- On-site child care and child treatment.
- A wide variety of groups including:
  - NA/AA meetings
  - Substance abuse education
  - Parenting skills
  - Mothers' support group
  - Sexuality
  - AIDS education
  - Vocational/educational issues
  - Health, personal care and nutritional counselling
  - Exercise/relaxation group
  - Aftercare planning.
- Services for families:
  - Films and discussions
  - Short term family group treatment
  - Individual, couple and family treatment for family members
  - Joint treatment of mother and children
  - Individual work for residents on family issues.

4. Outpatient programme

- Women's groups including:
  - Substance abuse education
  - Decisions about drinking/drugging groups
  - Short-term and long-term clean/sober groups
  - Special groups for special populations, such as:
    a. Pregnant women
    b. Mothers
    c. Lesbians
    d. Elderly women
    e. Young women

- Short and long-term groups addressing family issues:
  - adult daughters
  - children
  - friends and partners.
- Short and long-term individual counselling for substance abusing women and for those close to them.
- AIDS education and support.
- Child treatment.
- Child care provided for all groups.

While we believe that all of the elements identified are important, we wish to emphasize the importance of child care in the treatment of women. The lack of child care is a major deterrent to entering treatment for many women. Hence, providing (or arranging for provision of) child care services is a very important component of treatment for many women. (Reed, 1987, p. 161)

One of the most frequently raised questions relative to treatment of chemically dependent women is whether women should be treated in integrated or segregated programmes. Staff associated with chemical dependency programmes on PEI and elsewhere, who were interviewed during this study, held quite different views on this issue. Here again, however, the literature suggests that this is not an "either or" question. In Broadening The Base Of Treatment For Alcohol Problems, the authors note that segregated programmes for special populations may be feasible and desirable for some phases of treatment but neither practical nor optimal during others. They point out that in the early stages of treatment (detoxification, crisis intervention and self-assessment) all persons with alcohol problems have similar needs. However, it appears that once an individual has come to terms with their alcohol problem, other personal and social factors become more important in treatment. (Institute of Medicine, 1990, p. 402-403) Clinical observations suggest that

> "...once the crisis is past, many special population members are apt to reject further recovery in mainstream programmes in which they feel uncomfortable because of their special identity or that do not meet their special needs. The predictable result is a high rate of readmission to crisis-oriented treatment—the so-called "revolving door" problem."(Institute of Medicine, 1990, p. 403)

This is not to suggest that all women should be treated in segregated programmes. As Reed notes:

> "All-women programmes clearly are able to reach those who would otherwise not be in treatment, but whether or not they are useful or needed by all women is not yet clear. However, at least some period of all-women groups is likely to be very useful for most women, given the generally problematic dynamics of mixed groups for women". (Reed, 1987, p. 161)

As noted above, this objective can be met through a variety of treatment options.

C. Staffing mix and qualifications are also important

The literature indicates that staffing standards relative to staff to client ratios, educational qualifications, mix of professional to lay workers, or any other factors have not been developed for chemical dependency programmes. However, there appears to be general agreement that dealing effectively with the variety of problems associated with chemical dependencies requires a multi-disciplinary staff comprised of a mix of professional and recovering persons. Some studies also suggest that a richer mix of professional staffing may be beneficial in treating women.

A study noted in Getting Sober, Getting Well found that women came to agencies that hired more professionals, provided treatment for children and provided aftercare services. (Women's Alcoholism Programme of CASPAR, 1989, p. 165). Furthermore, "Those who work with drug dependent women...report that they need to work with a larger variety of individuals and groups in order to assist women optimally. These include children, partners, friends, parents and others." (Reed, 1987, p. 157). This reflects the fact that "Women in general are more responsive to social relationships and more concerned about them than men." (Reed, 1987, p. 157). Reed notes that working with a wide variety of groups "...takes more time and different skills than the more common types of individual and group work in drug dependence treatment agencies." (Reed, 1987, p. 157) Hence, providing more professional staff may be desirable when treating women.

Whether treating women in integrated or segregated programmes, staff must be sensitive to women's needs for special programming. This can be accomplished through education and by ensuring an appropriate mix of male and female staff.

Most of the agencies we contacted that have women-only programmes indicated that in their experience, an all-women staff is ideal for all-women groups.

A final important point about staffing that applies to treatment for all groups is that matching the belief systems of clients to those of staff may also be important in sustaining the clients' involvement in treatment. (Institute of Medicine, 1990, p. 245)

D. Programme evaluation is essential

The importance of outcome determination cannot be over-emphasized, both from the standpoint of furthering knowledge of what treatment options produce the best results and for purposes of justifying continued funding. To date, researchers have relied heavily on randomized clinical trials (RCT) to evaluate treatment outcome. However, while RCT is a powerful tool, it is difficult to use in many settings. Outcome evaluation is easier to use and may complement findings from RCT's. However, positive results may be due to factors other than treatment. The authors of Broadening the Base of Treatment for Alcohol Problems suggest that:

> "...external evaluation of treatment outcome (by those not connected with the provision of treatment) provides protection against bias and is in general to be preferred; however, internal examination of treatment outcome can provide important guidance for programme decision making". (Institute of Medicine, 1990, p. 9)

V

Addiction Services In Other Provinces

As part of our study, we surveyed other jurisdictions to obtain current information on trends in services for women. Other provinces whose addiction services we have profiled include New Brunswick, Nova Scotia and Newfoundland and Labrador.

A. Alcohol and drug dependency services in New Brunswick

Chemical dependency services in New Brunswick are offered through the Alcoholism and Drug Dependency Commission (ADDC). The Commission operates seven treatment (detoxification) centres that provide a total of 100 beds and 2 residential rehabilitation centres totalling 42 beds. In addition, a one week day programme for rehabilitation is offered in one city in the province. Outpatient counselling is provided at each centre as well as in several other locations in the province. A 46-bed extended care facility for men is also operated by ADDC.

ADDC uses the medical model and promotes follow-up through Alcoholics Anonymous or other such groups.

1. Detoxification

Detoxification and assessment services are segregated by sex. Staffing for each centre includes a regional director, head nurse, an RN and an attendant (24 hours/day, 7 days/week). Medical services are provided by family physicians on an on-call basis. Outpatient social workers are also available to detoxification clients.

2. Rehabilitation

a) 28 day residential programme

The two in-residence rehabilitation programmes run 7 days/week for four consecutive weeks. For the past few years, one centre has run segregated programmes for women (3 per year). When the female only programmes are offered, they run concurrently with a male only programme. Meals are taken together. Physical facilities and programming are, however, segregated to the extent that staffing levels permit. For the female only programmes, all therapeutic staff are female. Special programmes, including educational sessions on birth control, sexually transmitted diseases and legal advice are included whenever possible in the women's rehabilitation programme.

b) Detox plus

Detox Plus is a 5-day intensive rehabilitation programme for dependent persons who have been drug/alcohol free for at least one month. This programme is only offered at one location in New Brunswick, although the Commission is considering establishing a similar programme in one other location.

The programme generally accommodates 6 to 8 clients at a time and usually includes men and women. Staff includes a programme director and nursing staff from the regional detox programme. Members of AA and Al-Anon also participate in the programme.

The programme director advised us that an evaluation completed about three years ago indicated that 66% of Detox Plus clients surveyed remained sober after one year. He also noted that the programme provided a good solution to child care problems for women.

3. Aftercare

Aftercare services in New Brunswick include the following:

- Outpatient counselling
- Women's support groups
- Lonewater Farm.

a) Outpatient counselling

Outpatient counselling is provided throughout the province by professional staff and recovering persons.

b) Women's support groups

In the spring and fall of each year, fourteen 1.5 hour sessions are offered for women (post rehabilitation, or for any other women wishing to attend). These sessions focus on decision making, assertiveness, self image and other topics as well as providing general support. Staff from the treatment centres have received special training in these topics to assist them in conducting these sessions. Ideally, the women's support sessions are held in each area with a treatment (detox) centre, although the sessions are held off-site.

c) Lonewater Farm

Lonewater Farm is a 46-bed extended care facility for men.

4. Other services

a) Education and prevention

Each region has 2.5 community addictions counsellors who may be recovering persons or professionals. The focus of these positions is education and prevention.

b) Youth services

Currently no special programmes or facilities are available for youth. However, the province employs 4.0 youth counsellors. The Commission considers development of additional services to serve this group top priority.

5. Amana House

Amana House is a long term residential recovery facility for women with chemical dependencies located in Saint John, New Brunswick. Services at Amana House are also available to women who prefer day treatment. This facility is operated by an independent board and is outside the jurisdiction of the Alcoholism and Drug Dependency Commission.

Amana House has nine beds, of which four or five are occupied most of the time. Staff in the programme are a mix of professionals and recovering persons. Programmes at Amana House are based on the AA model of recovery and the Hazelden model.

Due to the very limited staffing at Amana House, we were unable to obtain any further information on this facility and its programmes.

6. Service utilization by women is increasing

Exhibit V-1 provides information on female utilization of three services of ADDC over the past four years. Overall utilization increased during the period, with particular increases occuring in detoxification and outpatient programmes.

Exhibit V-1
Service utilization by women—Alcoholism and Drug Dependency Commission of New Brunswick

	1986/87		1987/88		1988/89		1989/90		
	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total	Change
Treatment	667	15.7%	756	16.5%	776	17.3%	718	17.1%	7.6%
Rehabilitation	56	12.4%	65	16.0%	81	18.6%	74	18.2%	32.1%
Outpatient	204	19.4%	259	21.0%	243	20.8%	262	25.2%	28.4%
Total	927		1,080		1,100		1,054		13.7%

Source: Alcoholism and Drug Dependency Commission of New Brunswick.

B. Alcohol and drug dependency services in Nova Scotia

Alcohol and drug dependency services in Nova Scotia are delivered by the Nova Scotia Commission on Drug Dependency and in one region, by an independent agency—Crosbie Centre in Kentville.

1. Nova Scotia Commission on Drug Dependency (NSCODD)

The mission of the Nova Scotia Commission on Drug Dependency (NSCODD) is to deliver regionalized and comprehensive services to drug-dependent persons in Nova Scotia. The Commission sees treatment and rehabilitation as a process that provides the individual with a broad range of therapeutic experiences within both professional and paraprofessional disciplines. The length and comprehensiveness of the processes of treatment and rehabilitation reflect the goal of establishing more positive lifestyles and behaviours. Vocational rehabilitation is a key objective in the total recovery process.

The Commission values and endorses many styles of therapeutic intervention and support. Through emphasis on the provision of a "continuum of care", treatment processes include both professional care and ongoing support offered by self-help groups.

The Commission officially endorses the "disease model" of treatment and rehabilitation, but views the "social learning model" as a useful and often necessary complementary approach to long term sobriety and recovery.

The major programmes of the Commission can be divided into three groups: primary care, aftercare and extended care. Other programmes include "Choices" (Youth Treatment and Education) and the Women's Clinical Resource Centre.

a) Primary Care

Primary care consists of three phases: detoxification, assessment and treatment orientation. The primary care programme emphasizes rest, personal hygiene and a balanced diet. Primary care services are delivered on an inpatient basis through five regional programmes.

NSCODD (including Crosbie Centre described in B-2) has a total of 80 beds, or 0.09 beds per thousand population, dedicated to detoxification and treatment orientation.

i) **Detoxification.** This is a voluntary programme in which the client withdraws from alcohol and/or other drugs in a supervised and supportive environment.

ii) **Assessment.** Assessment is a process of measurement, judgement and appraisal that determines the nature of the chemical dependency and the degree of impact on the life of the individual

and others. From the assessment, a tentative treatment plan is developed.

iii) **Treatment orientation.** The Treatment Orientation Programme takes place near the end of the withdrawal process. Organized as a 5-day education programme, it focuses on the "here and now" and links individuals to ongoing follow-up and aftercare services for varying periods of time. Separate women's treatment orientation programmes are offered.

b) Aftercare

Aftercare includes the 28-day rehabilitation and non-residential programme and satellite outpatient services. These services recognize that chemical dependency is a chronic and relapsing illness that requires ongoing treatment and rehabilitation.

i) **Residential and non-residential rehabilitation programmes.** NSCODD has a total of 48 beds (or 0.05 beds per thousand population) dedicated to residential rehabilitation programmes throughout 4 of its 5 regions .

The 28-day programme is offered on either an inpatient or an outpatient basis. All women's 28-day programmes are held periodically (about three times per year) in both the Metro/Lunenburg Region and the Cape Breton region. The reasons for operating an all women's programme are expressed well by Kathy Philip, a nurse and rehabilitation counsellor in the Metro/Lunenburg region:

"Women in a female group are more talkative, open and honest about their feelings and ideas. They are able to share their concerns, hopes and fears to a far greater extent than they do in a mixed group. Women in a mixed group tend to allow male participants to "carry the ball" in discussions and look to the men for approval and/or rescuing. The men are quite willing to assume a protective role towards the women. This interaction, I believe, is not therapeutic for either sex. It reinforces the need to continue to offer women's treatment programmes."[1]

---

[1] *Changes: A Newsletter Dedicated To The Well-Being Of Women, Vol. 1, No. 2, February 1989, NSCODD.*

ii) **Outpatient Clinics.** Aftercare outpatient clinics are satellites of the regional offices. Outpatient clinics provide a variety of counselling services on an individual, group, or family basis. An all women's 5-day therapeutic outpatient programme is offered in the Metro/Lunenburg region.

Wherever possible, outpatient clinics are staffed by a "team" composed of a community health worker, a clinical therapist (professionally trained counsellor) and a secretary/receptionist. A nurse/rehabilitation counsellor, if available, is an additional resource to the outpatient clinic team.

iii) **Halfway Houses.** Nova Scotia has a total of 16 beds in half-way houses—8 in Cape Breton and 8 in Metro/Lunenburg. No female halfway houses are currently in operation.

c) Extended Care

Extended care programmes provide long term care for clients with chronic disabilities related to drug dependency.

Extended care is currently provided to male Nova Scotians through long-term sheltered workshops in Cape Breton (31 beds) and Metro/Lunenburg (16 beds). No facilities for women are available.

d) Youth Treatment and Education

Choices is a specialized treatment centre of NSCODD offering assessment, treatment and education to youth, ages 14 to 18. Programme components include assessment, outpatient services, a 12-week day programme, a 16-week inpatient programme, follow-up services and family counselling and assistance.

e) Women's Clinical Resource Team

Funded as a joint project of NSCODD and Health and Welfare Canada's National Drug Strategy, the Women's Clinical Resource Team (WCRT) was initiated 3 years ago to enhance existing treatment programmes for chemically dependent women in Nova Scotia. As part of NSCODD's library services, a Women' Resource Centre was established to "help in the rehabilitation of women addicted to alcohol or other drugs". The Centre's goal was to support a holistic approach to the treatment of female addictions. Although the 3-year project is now complete, the Centre's materials on health, sexuality, life and vocational skills and parenting techniques have been incorporated into NSCODD's library.

The WCRT also published a quarterly newsletter entitled "Changes: A Newsletter Dedicated to the Well-being of Women", and sponsored the development of a staff development manual entitled "Women, Emotions and Chemical Dependency". A self-learning manual entitled "Women and

Chemical Dependency" was completed in November, 1990. This manual will be used by the WCRT in staff training at centres around the province. It provides background, assessment and training information for sessions on five major areas:

- Counselling (specific to women's issues and circumstances)
- Sexuality
- Emotions
- Parenting
- Adult Children of Alcoholics.

Women's programmes are becoming a top priority in many of NSCODD's regions and funds are sometimes redirected internally to support new programmes for women.

NSCODD's aftercare philosophy includes roles for community health workers, professional counsellors and self-help groups. Recognizing the disadvantages of mixed gender AA groups, NSCODD often encourages women to participate in other available support groups. An all-women's AA group meets in Dartmouth and a community-based self-help group for recovering women meets in Halifax.

2. Crosbie Centre—Kentville, Nova Scotia

In 1978, a comprehensive drug and alcohol treatment programme based on the AA model of recovery was established by the Kentville Hospital Association. This programme is independent of the services provided by the Nova Scotia Drug Dependency Commission.

The programme consists of a 5-bed detoxification unit, a 10-bed treatment and rehabilitation unit offering a 28-day programme and a community-based follow-up programme.

a) Detoxification

A 5-bed unit, located in the hospital provides detoxification services for both men and women. Unlike the Nova Scotia Drug Dependency Commission's practice, the treatment orientation programme is completed during the detoxification period. An "Aftercare Coordinator" is responsible for the development of an aftercare plan for all clients. This person also plays a role in coordinating specific aftercare services discussed below.

b) Residential treatment programme

A 10-bed residential treatment programme is offered for men and women. This programme is integrated but opportunities for individual counselling with

male or female counsellors are provided. Staffing for the 28-day programme includes two counsellors (one professional and one recovering person), a night attendant, the family counsellor and a chaplain.

c) **Aftercare**

i) **Aftercare services.** Aftercare services are provided through the following:

- 2-year follow-up programme.
- 3 community health workers.
- Referral of clients from outside the three county-catchment area to NSCODD offices for outpatient counselling.
- Outpatient counselling by the family therapist.
- Referrals to other agencies.

Crosbie Centre staff considers the 2-year follow-up programme to be a key factor in the success of their programme. While clients are in either detox or the 28-day programme, they are asked to choose a buddy who, on a volunteer basis, will maintain contact and provide support for a 2-year period. During the first year the suggested frequency of contact is weekly, reducing to monthly in the second year. Each month the contact person formally reports to the aftercare coordinator on the client's progress.

ii) **Community health workers.** Each of the three counties served by Crosbie Centre has a community health worker (a recovering person) whose responsibilities include:

- Counselling ex-patients and their families.
- Serving as a resource for the volunteer contact persons.

iii) **Family therapist.** The family therapist who provides service to other Crosbie Centre programmes also provides counselling for clients and their families in aftercare.

iv) **Referrals to other agencies.** Crosbie Centre strongly encourages client involvement in support groups such as AA and Al-Anon. In addition, clients are referred to other agencies such as mental health programmes, employment agencies, social services agencies and others.

d) Other services

Crosbie Centre employs a full-time coordinator of education and health promotion whose role is to foster better public understanding of alcoholism and drug dependency programmes through information and education.

3. Innovative developments in dependency services for women in Nova Scotia

Two years ago, the regional drug dependency office in Sydney piloted a 28-day rehabilitation programme for females only. Based on the success of this pilot, the Sydney programme now offers every third programme as a "women's only" programme. Programme content has been tailored to meet the needs of women.

As much as possible, all female staffing is provided. Most women, especially victims of sexual abuse, wait to get into the all women's programme. Unlike other 28-day programmes, women with concerns about child care arrangements, may attend on a day basis. These women stay until programming for the day ends at 7:30 p.m.

In July, 1990, the Sydney centre piloted a day rehabilitation programme with a child care component. The programme was offered from 9:00 - 4:00, Monday to Friday, for four weeks. Physical facilities were modified to allow half of the unit to be used for the rehabilitation programme, and the other half for child care. Eleven women and fourteen children, ranging in age from three months to eleven years participated. The child care component was staffed using a mixture of child care university degree programme students and professional staff from other Commission programmes.

We were advised that the province of Nova Scotia has now adopted this as the most cost effective model for rehabilitating women suffering from dependencies. A proposal has been submitted with this year's budget request to establish such a programme in one region of the province. Eventually the Commission hopes to have these programmes available throughout the province. Child care may be contracted out to child care providers.

A shelter for women with addictions has recently been established in North Sydney and Sydney Mines. The physical facilities for this shelter are provided by the Sisters of Notre Dame. Women living in the shelter must have a drug and/or alcohol problem, and must be drug or alcohol free at the time of admission to the shelter. Residents frequently attend the 28-day programme and/or the outpatient counselling services of NSCODD.

4. Female service utilization has increased in Nova Scotia

Exhibit V-2 shows that female utilization of services offered by NSCODD increased between 1985/86 to 1988/89 both in absolute terms and as a percentage of overall utilization. In Cape Breton, where a women's 28-day residential rehabilitation programme has been operating, female participation increased by 40% from 1985/86 to 1989/90. Much of this increase occurred in the outpatient programmes. In Cape Breton, twice as many women participate in outpatient programmes as in the inpatient programmes. Overall female utilization in NSCODD programmes has increased from 12% in 1977/78 to 20% in 1989/90.[1]

Exhibit V-2
Female participation in NSCODD programmes

	1985/86		1986/87		1987/88		1988/89[2]		
Programme	Female	% of Total	Female	% of Total	Female	% of Total	Female	% of Total	% Increase
Detoxification (Discharges)	351	9.7%	487	14.1%	518	15.4%	524	15.6%	49.3%
Residential Rehabilitation (Clients)	86	16.1%	94	17.8%	93	17.9%	108	20.0%	25.6%
Outpatient Services (Clients)	945	19.1%	1,057	19.6%	1,186	19.9%	1,151	19.4%	21.8%
Total	1,382	15.2%	1,638	17.5%	1,797	18.3%	1,783	18.2%	29.0%

[1] *Telephone interview with Patricia MacNeill, Coordinator of Documentation, Evaluation, and Research, NSCODD.*

[2] *Unpublished data.*

C. Alcohol and drug dependency services in Newfoundland and Labrador

Chemical dependency services in Newfoundland and Labrador are offered through the Alcohol and Drug Dependency Commission of Newfoundland and Labrador (ADDC). The Commission operates five regional offices that provide outpatient counselling, a 21-bed detoxification centre in St. John's, and a residential rehabilitation centre.

In addition to services provided through the Commission, a number of other agencies and organizations, including private for-profit agencies, hospitals, correctional facilities and religious groups provide services for persons with drug and alcohol dependencies.

ADDC has produced a directory of addiction treatment services available in the province. This is a valuable resource for existing and potential clients, families, service providers and others.

The ADDC operates from a bio-psycho-social model, that is from the belief that every area of a person's life is affected by their drug use, and biological, psychological and social factors need to be taken into account during treatment. Services include:

1. Detoxification

Until this year, a 21-bed non-medical detoxification centre in St. John's has only been open for men. As of April, 1991, it will be open to women. It is staffed by paraprofessional staff.

A 2-bed detoxification centre also operates at the Dr. Charles L. LeGrow Health Centre in Port aux Basques.

2. Rehabilitation

The 21-day in-residence rehabilitation programme offered in St. John's serves males and females, 18 years or older. Beginning in 1991, the centre will be offering "all women" programmes as well as integrated rehabilitation programmes. Staffing includes a mix of professional and paraprofessional staff.

A 10-bed rehabilitation programme in Corner Brook has recently been started at the Humberwood Centre.

3. Outpatient

Outpatient counselling for individuals, families, groups, and marital counselling is provided from the five regional offices.

4. Future Plans

In future, the Commission hopes to provide a continuum of services to include detoxification, inpatient, outpatient, and day programmes throughout the province. They also hope to provide integrated and segregated programmes for sub-groups such as women and adolescents.

D. Other jurisdictions

Throughout the rest of Canada and the United States various approaches are being developed to meeting women's needs for addiction services. We have not catalogued these here. However, because a number of persons interviewed expressed interest in Amethyst Women's Addiction Centre in Ottawa, we briefly outline its services.

The Amethyst Treatment Programme offers a day treatment programme to women who are dependent on alcohol and/or drugs. The total programme lasts for two years and consists of the following elements.

- Phase I—Assessment. A woman seeking treatment must contact Amethyst herself to arrange an assessment. If Amethyst seems appropriate to her needs, the woman enters pretreatment. If not, she is referred to another facility.

- Phase II—Pretreatment. This involves individual counselling in conjunction with the woman's physician to support a woman as she detoxifies. Once detoxified she enters support groups which meet several times a week.

- Phase III—Ten day treatment. This phase is offered every 5 weeks. During this 10 day period a maximum of 12 women meet with qualified counsellors in group therapy and educational sessions.

- Phase IV—Two year follow-up. Follow-up groups are held several times a week and short term individual counselling is also available.

The Amethyst health promotion programme serves both professional and community groups. Its goal is to encourage groups to look critically at their attitude towards addiction and to increase their knowledge and awareness of drug use and effects, particularly as these affect women. Specific services include:

- Speaking to service clubs, women's groups, schools and other community groups.

- Providing workshops for professionals interested in identifying confronting addiction problems in women and referring clients for treatment.

- Offering youth programmes providing six week health promotion sessions to groups of high risk young women.

- Conducting a childrens' education programme for children aged 8 - 12 whose parents are in recovery.

VI

Addiction Services On PEI

In this chapter we provide an overview of the services available on PEI for the treatment of women with chemical dependencies.

A. Historical background

"Keep the temperate people temperate; the drunkards will soon die, and the land be free" (Institute of Medicine, 1990, p.74). This sentiment, expressed in 1822 by Justin Edwards, a leader of the temperance movement in the U.S., typifies society's prevailing attitude toward addictions until relatively recently. Alcohol addiction, to the extent that it was recognized, was viewed as a moral rather than a medical matter.

The single most important development in the history of addiction services occurred two years after the repeal of the U.S. prohibition legislation in 1933 -- the founding of Alcoholics Anonymous. By the mid -1960s, international authorities were beginning to recognize alcoholism as a disease requiring treatment, rather than just a form of social deviance calling for condemnation and punishment. (Institute of Medicine, 1990, p.14)

The Alcoholism Treatment Foundation was established on PEI in 1966. The Report of the Premier's Task Force on Extended Care and Alcoholic Treatment Facilities in 1969 laid the groundwork for many addiction services found on the Island today. The report accepted alcoholism as a disease requiring treatment and initiated a gradual change in the public perception of alcohol problems. The Alcoholism Treatment Foundation became the Province's officially recognized agency for the treatment of alcohol and other addictions and in 1973, became known as the Addiction Foundation of PEI.

The Addiction Foundation of PEI Act in 1975 designated the Foundation a Crown Corporation responsible to the Minister of Health for addiction prevention and treatment services. In 1979 an Advisory Committee on Alcohol and Drug Addiction Treatment Prevention Services on Prince Edward Island recommended decentralization of addiction services through contractual arrangements with three private non-profit county boards. The Foundation was renamed PEI Addiction Services and, through the Addiction Services Act, the Minister of Health and Social Services was assigned responsibility for the "planning, co-ordination, and delivery of programmes relating to alcohol and drug abuse in the province." To accomplish this, the Minister was empowered to:

- Contract with community organizations for the provision of service to the regions.
- Establish minimum standards for treatment.
- Evaluate programmes on a regular basis.

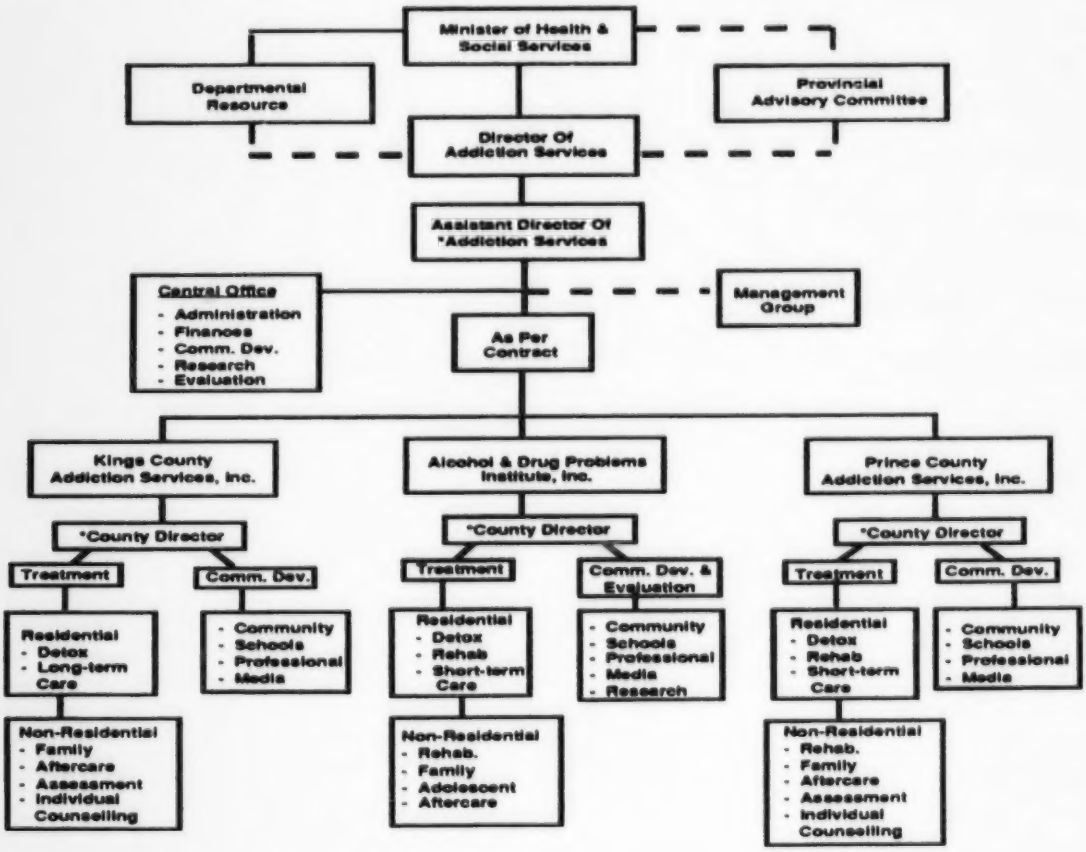
- Operate clinics.
- Provide for public and staff education.
- Support appropriate research initiatives.

The Act also stipulated the appointment of a Director to assist and advise the Minister. A subsequent regulation to the Act in 1985 allowed for the creation of a Central Office for Addiction Services.

B. Structure and organization of Addiction Services of Prince Edward Island

Exhibit VI-1 depicts the organization of Addiction Services of PEI.

Exhibit VI-1
Organization of Addiction Services of PEI



*Denotes member of Management Group.

The mandate of the Central Office is to:

- Establish guidelines and engage in an ongoing monitoring and evaluation process with the contracted County agencies.
- To develop and implement research and evaluation programmes as requested by the County agencies.
- To oversee the management of financial matters in consultation with the County agencies.

Reporting directly to the Minister, the Director of Addiction Services supervises the staff of Central Office and acts as the provincial representative on the federal-provincial "Advisory Committee on Alcohol and Other Drug Problems".

The Central Office staff works closely with the staff of the three county agencies. These are:

- Kings County Addiction Services.
- Alcohol and Drug Problems Institute (Queens County Addiction Services).
- Prince County Addiction Services.

Each of the County agencies is a private non-profit corporation administered by a board of directors that sets policy, allocates funds and employs a County Director. Each County Director administers the treatment and educational programmes in their respective counties on behalf of the boards.

C. Addiction Services of Prince Edward Island—programmes and services

Exhibit VI-2 summarizes the programmes offered to Island residents through the three county agencies. Although the specific services vary somewhat among the three counties, each offers a range of both residential and non-residential treatment programmes and community development services.

Exhibit VI-2
Programmes and services of Addiction Services of Prince Edward Island

Services	Kings County	Queens County	Prince County
Detoxification	X	X	X
Detox—follow-up	X		X
Residential rehabilitation		X	X
Non-residential rehabilitation	X	X	X
Counselling services	X	X	X
Residential assessment—police		X	
Residential Halfway House:			
Male	X (Georgetown)	X (Talbot)	X (St. Eleanor's)
Female		X (Lacey)	
Family programmes (non-res.)	X	X	X
Aftercare	X	X	X
Parole Programme		X	X
Impaired Driver Programme	X	X	X
Early Release Programme		X	X
Public relations and information/ community development	X	X	X

1. Kings County Addiction Services

Kings County Addiction Services, located in Souris, operates the following services:

- A 12-bed Residential Detoxification Programme. The primary purpose of this unit is to allow safe withdrawal from chemicals under medical supervision and to motivate and guide clients to further treatment. The unit also admits sober patients experiencing difficulties for stabilization and counselling.

- Non-residential Aftercare. This weekly service is available to all persons who have completed a residential or non-residential rehabilitation programme. The recommended length of stay is one year. Some all female groups have been available in the past, but they have been discontinued due to insufficient interest. Counsellors include both males and females.

- Non-residential Rehabilitation. This is a new programme providing non-residential rehabilitation for men and women.

- Georgetown House. This ten-bed long term care facility in Georgetown accommodates men with chronic chemical dependencies. The daily programme consists of group discussion, individual counselling, films, life skills training and residential and community meetings of Alcoholics Anonymous. The information and drop in centre, also operates out of Georgetown House.

A school and community information programme is also offered by Kings County Addiction Services. This programme is delivered through many community groups and emphasizes youth. Kings County also offers a family programme involving information and support to families of persons with chemical dependencies. Individual counselling is offered in addition to group sessions.

2. Queens County Addiction Services/Alcohol and Drug Problems Institute

The Alcohol and Drug Problems Institute (ADPI) provides a number of treatment and education services through Queens County Addiction Services (QCAS). QCAS provides the following:

- Residential Detoxification - Phase I. This 22-bed unit provides safe detoxification under medical and nursing supervision, assessment, motivation and information to persons with chemical dependencies. Eight of these beds are designated for female detoxification and residential rehabilitation. Referrals come from a number of agencies including hospitals, probation services, employers, the parole system, Social Services and the Highway Safety Division.

- Residential Rehabilitation Programme - Phase II. Patients are admitted to this programme from the detoxification unit. The programme is approximately 21 days in length and includes group information, therapy (delivered at ADPI) and individual counselling. Female participants are accommodated together with female detoxification clients in one end of the detoxification unit, while male participants are accommodated on a separate floor. Group sessions are gender integrated, as well as being integrated with the outpatient (non-residential) programme clients.

- Non-residential Rehabilitation Programme. This programme offers a 2-hour daily informational programme plus individual counselling and assessment.

- Residential Assessment Unit - Police Unit. This unit provides the following:

  - Short-term protection for persons referred by police for public drunkenness.

  - Short-term care and assessment for referrals from the outpatient department of the Queen Elizabeth Hospital.

  - Short-term detoxification for persons so requesting or requiring it.

  The unit is supervised by nursing staff of the detoxification unit.

- Residential Halfway House - Talbot House. This is an 18-bed halfway house for men requiring a period of support after rehabilitation and before fully re-entering the community.

- Non-residential Family Programme. This information and support programme for families of persons with chemical dependencies is staffed by a family therapist supported by other staff and volunteers. Both agency and self-referrals are accepted. The programme consists of 10 weekly information sessions of two hours duration. Individual counselling is also available as necessary.

- Aftercare - Phase III. Aftercare is recommended for all persons completing rehabilitation. It consists of weekly attendance at a group session plus attendance at two community meetings of self-help groups, primarily Alcoholics Anonymous. In addition, monthly individual counselling is available as necessary. Length of stay in aftercare is recommended to be six months minimum, but can be extended to one year. QCAS is planning to develop some all female aftercare groups.

- Parole Programme. This is a three week residential programme followed by two months at a half-way house.

- Impaired Driver Programme. This programme utilizes the assessment and treatment services defined previously for persons with three or more convictions for impaired driving. It operates in conjunction with the Highway Safety Division.

- Early Release Probation Programme. By participating in treatment services previously defined, persons incarcerated at the Provincial Corrections Centre may be released early under this programme.

- Public Relations And Information Programme. This programme targets youth, through the schools and community groups, with the objective of preventing substance abuse.

- Lacey Residence. When negotiations to operate Mann House under Addictions Services collapsed, the Minister of Health and Social Services requested QCAS to assume responsibility for providing extended care for women. QCAS responded by opening Lacey Residence, a ten bed facility in Charlottetown, in January 1991. Lacey Residence provides treatment and shelter for women needing further support beyond detoxification and rehabilitation prior to full re-entry into the community.

- Assessment And Treatment For Adolescents. This is a non-residential treatment programme for adolescents with one year follow-up.

- Children Of Alcoholics. Programmes for teenage children of alcoholics and adult children of alcoholics are offered.

3. Prince County Addiction Services

Prince County Addiction Services, based in Summerside, provides services to the western part of the province. Programmes include:

- Primary care (Detoxification). 17 beds are provided for both detoxification and residential rehabilitation for males and females. Two of these are designated for females.

- Intermediate Care (Rehabilitation). This three week programme may be taken as a resident or day case. Treatment is identical for both and delivery is gender integrated. Female residential clients stay at the Primary Care Unit while male participants may be accommodated at the Primary Care Unit or at St. Eleanor's House, the halfway house for men. In a closed, small (maximum 12) group setting, clients explore in depth, the nature of chemical dependency. Programme clients are encouraged to use the group as their main support system, together with AA, after programme completion.

- Aftercare. All clients are urged to participate in the small group weekly aftercare programme for one year. Two groups operate in the West Prince area to provide easier access by residents of that area.

- Family Care. Information sessions, individual counselling, and referral to related services are offered to families and concerned members of the public.

- West Prince Counselling Service. A community addictions counselling resource is provided in the western area of Prince County. Staffed by a full-time counsellor with backup of other agency staff, this service provides assessment, counselling, referral and follow-up counselling for residents of West Prince. The Counsellor has office hours weekly in Summerside, Alberton and O'Leary.

- Extended Care. A 12 bed facility for men, St. Eleanor's House, provides preparation for re-entry.

- Non-residential services. Assessment, counselling, antabuse administration and drug screening services are offered. Referrals come primarily from the justice system, Highway Safety Division and employers.

- Community Development Services. Under the direction of the community development coordinator, this programme's purpose is to raise public awareness of issues related to chemical dependency. A library of information is available to the public at the Addiction Centre in Summerside. Numerous information activities are also conducted.

4. PEI is well endowed with inpatient beds

a) Detoxification programmes

Exhibit VI-3 shows the distribution of detoxification beds and beds per thousand population within PEI compared to other Atlantic Canada provinces. The 0.44 detoxification beds per thousand population on PEI compare with 0.09 designated detoxification and treatment orientation beds per thousand in Nova Scotia. While direct comparisons are misleading because a portion of the detox beds on PEI are used for rehabilitation, it is clear that PEI is well endowed with beds relative to all other Atlantic provinces. Within PEI, Kings County stands out as having a bed ratio approximately double the provincial average.

Exhibit VI-3
Detoxification beds - Addiction Services of PEI and Atlantic provinces

	Beds	Population[1] (000's)	Beds/thousand Population
Queens	22[2]	63.5	0.35
Kings	17	19.5	0.87
Prince	17[3]	43.7	0.39
Total PEI	56	126.6	0.44
Nova Scotia	80	887.7	0.09
New Brunswick	100	720.7	0.14
Newfoundland and Labrador	23	572.4	0.04

[1] *Statistics Canada, 1986 Census.*

[2] *This includes 14 male and 8 female beds. The female beds accommodate both detoxification and rehabilitation.*

[3] *This includes 15 male and 2 female beds, as well as rehabilitation.*

b) Rehabilitation programmes

Exhibit VI-4 shows the distribution of designated residential rehabilitation beds within PEI and the three other Atlantic provinces. In addition to the high bed ratio of detoxification beds discussed previously, PEI is also well endowed with rehabilitation beds relative to the rest of Atlantic Canada.

Exhibit VI-4
Residential rehabilitation beds - Addiction Services of PEI

	Beds	Population (000's)	Beds/thousand Population
Queens	16+	63.5	0.25
Kings	0	19.5	0.00
Prince	*[1]	43.7	n/a
Total PEI	16+	126.6	0.13
Nova Scotia	42	887.7	0.05
New Brunswick	48	720.7	0.07
Newfoundland and Labrador	36	572.4	0.06

[1] *Some rehab in detox beds.*

c) Overall bed ratios

Exhibit VI-5 shows the total detoxification and rehabilitation beds for the four Atlantic provinces. PEI has more than three times the beds per 1000 population of the other three provinces.

Exhibit VI-5
Interprovincial comparison of beds for inpatient addiction services

Province	Detox	Res. Rehab.	Total	Population (000's)	Beds/Thousand
New Brunswick	100	42	142	720.7	0.20
Nova Scotia	80	48	128	887.7	0.14
Newfoundland and Labrador	23	36	59	572.4	0.10
PEI	56[1]	16	72	126.6	0.57

[1] *Although designated as detoxification beds, some of these are available for residential rehabilitation as required.*

5. Utilization of addiction services by women

a) Detoxification programmes

Exhibit VI-6 shows female admissions as a percentage of total admissions to the Island's three detox centres over the past four years. Consistent with other provinces, female utilization of detox services is much lower than male utilization. However, female utilization in Queens County has been significantly higher than in the other two counties. Of concern, however, is that the number has dropped over time in two of the three counties, and in the province as a whole. Although Nova Scotia's percentage of female utilization of detox services is slightly lower than that of PEI, (15.6% versus 16.4%) Nova Scotia's trend is in the opposite direction (Exhibit V-1). New Brunswick is also experiencing increased utilization of treatment services.

Exhibit VI-6
Female admissions as a percentage of total admissions to detoxification programmes - Addiction Services of PEI

	1986/87		1987/88		1988/89		1989/90	
County	Number	% of total	Number	% of total	Number	% of total	Number	% of total
Kings County	22	4%	45	10%	41	9%	45	10%
Queens County	187	23%	160	20%	119	16%	145	20%
Prince County	97	15%	85	13%	62	11%	62	11%
Total	306	18%	290	18%	222	14%	253	16%

With the highest ratio of detoxification beds, Kings County has the lowest utilization by females. However, female utilization has increased in Kings, while declining in Queens and Prince.

b) Rehabilitation programmes

i) **Residential rehabilitation.** Rehabilitation programmes are offered in all three counties, although residential accommodation is provided in only Queens and Prince counties. Exhibit VI-7 shows female utilization of residential rehabilitation services. Female utilization has not been higher than 22% over this four-year period. As with detox services, Queens County shows higher rates of female utilization.

We are concerned that overall utilization by females has declined substantially over the period. By comparison with other Atlantic provinces, PEI's rate is low. Nova Scotia's female utilization of residential rehabilitation services was 20% in 1988/89, and the trend in Nova Scotia has been upward. Similarly, female

rehabilitation utilization in New Brunswick has been increasing and was over 18% in 1988/89.

Exhibit VI-7
Female admissions as a percentage of total admissions to residential rehabilitation programmes - Addiction Services of PEI

County	1986/87 Number	1986/87 % of total	1987/88 Number	1987/88 % of total	1988/89 Number	1988/89 % of total	1989/90 Number	1989/90 % of total
Kings County	no residential programme							
Queens County	78	22%	84	21%	52	15%	53	18%
Prince County	25	15%	29	15%	13	9%	12	8%
Total	103	19%	113	20%	65	13%	65	15%

ii) **Non-residential rehabilitation.** Non-residential or outpatient-based rehabilitation programmes are available in Queens and Prince Counties and recently have become available in Kings County. These programmes offer a daily group information programme, plus individual counselling and assessment. Length of stay is typically three weeks.

Exhibit VI-8 shows that female utilization in Queens County has declined in absolute terms, but increased slightly in relation to the male patient population. Female utilization in Prince County, as measured in outpatient days, has declined significantly over this period. Again, this trend contrasts with other Maritime provinces. Between 1985/86 and 1988/89, the number of female outpatient clients increased in Nova Scotia by 22%. Between 1986/87 and 1989/90, the number of female outpatient clients in New Brunswick increased by 28%.

Exhibit VI-8
Female admissions as a percentage of total admissions to non-residential rehabilitation programmes - Addiction Services of PEI

County	1986/87 Number	1986/87 % of total	1987/88 Number	1987/88 % of total	1988/89 Number	1988/89 % of total	1989/90 Number	1989/90 % of total
Kings County	Programme began in January, 1991							
Queens County	50	17%	44	17%	43	17%	40	18%
Prince County	n/a[1]	16%	n/a	10%	n/a	10%	n/a	9%

[1] *Percentage of females based on "outpatient days", not admissions.*

c) Aftercare programmes

Aftercare programmes are provided in all three counties. As Exhibit VI-9 shows, female utilization of these services is also disproportionately low and has dropped over time.

Exhibit VI-9
Female admissions as a percentage of total admissions to aftercare programmes - Addiction Services of PEI

	1986/87		1987/88		1988/89		1989/90	
County	Number	% of total	Number	% of total	Number	% of total	Number	% of total
Kings County	1	3%	2	12%	3	11%	1	4%
Queens County	42	19%	50	19%	42	17%	45	21%
Prince County	23	9%	26	11%	13	6%	12	6%
Total	66	13%	78	15%	58	12%	58	13%

Exhibit VI-10 summarizes information from an extensive aftercare follow-up study carried out by ADPI in 1989. 21% of aftercare programme participation was by women. Of these, 72% actually completed the programme. Although a higher percentage of males completed the programme, a higher percentage of women reported ongoing sobriety and attendance at support group meetings.

Exhibit VI-10
Alcohol And Drug Problems Institute (ADPI)—Queens County Addiction Services Aftercare Follow-up Study, 1987

	Males		Females	
	Number	Percentage	Number	Percentage
Completed programme	54	82%	13	72%
Sobriety since programme	24	36%	7	39%
Short slips from abstinence	29	44%	8	44%
Drinking regularly	13	20%	3	17%
Regular attendance at AA or other support group	41	62%	14	78%
Family members attending family programme	25	38%	5	28%

Total subjects	84
Males	66 (79%)
Females	18 (21%)

Data source: telephone survey of former aftercare clients
Source: Mr. Grant Killorn, ADPI

d) Extended care/halfway house programmes

Exhibit VI-11 provides some utilization indicators for the three counties' facilities for men. Average length of stay (ALOS) in these facilities tends to be relatively short.

Exhibit VI-11
Extended care/halfway house facilities - utilization profile—1988/89

	Talbot House Queens County	Georgetown House Kings County	St. Eleanor's House Prince County
Beds	18	10	12
Admissions	118	49	10
ALOS	35	40	34
% Occupancy	69%	58%	84%

D. Mann House

1. Purpose

While extended care facilities for men have been available for some time, it was not until 1986 that the first such facility for women opened on the Island. Although the gap in service for women was recognized, lack of funding had prevented service development.

A Canada Works application submitted by ADPI in 1985 sought approval to establish a "female halfway house - demonstration project". The objectives as stated on the application were:

- To provide a therapeutic homelike atmosphere with appropriate recovery programme for socially deprived women suffering from chemical dependency.
- To assist these women to gain the dignity and confidence to assume a constructive and gratifying role in society.
- To prepare residents to move back into the workforce and thus decrease welfare and social service costs.
- To continue as a supportive aftercare refuge for former residents.

The activities required to meet these objectives were outlined as follows:

- Counselling programme.
- Mandatory support meetings (AA, NA, etc.).
- Aversion therapy (i.e. antabuse, temposil).
- Assigned tasks (cooking, cleaning and general care of house).
- Social programme—learning to enjoy activities that do not require the use of chemicals.
- Learn job skills.
- Develop discipline and value system.
- Assist residents to obtain employment (which would probably begin before leaving the structured environment).

2. Organization and funding

A private board, Mann House Corporation, was established and eventually funds were provided through Employment and Immigration Canada to develop a demonstration project. While recognizing the desirability of offering this service, the Government of PEI made no commitment at that time to financial support. Subsequently several government grants, plus per diem funding were provided. However, Mann House was never considered as a full partner in provision of addiction services on PEI.

Funding was an ongoing preoccupation of the board. Funding sources included government grants, private donations, fundraising activities and per diem fees for residents. Special grants for research projects were also obtained from time to time. However, substantial reliance on the $34 per diem rate for eligible clients meant that heavy emphasis had to be placed on keeping the house full. Since county agencies were the main source of referrals, coordination between service providers was essential. The lack of strong coordination and cooperation led to the breakdown that ultimately resulted in the closure of Mann House.

3. Mann House made a significant contribution

At the time of our review, Mann House had already ceased admitting clients. However, it was still open for "drop-ins" and was clearly providing a support service for women.

Because we were unable to view Mann House "in action", we have relied on staff, former staff, board members and former residents of Mann House for the "internal" view and on staff of referring agencies for the "external" view. We interviewed many informants and received a wide range of views on both the strengths and weaknesses of Mann House. Discussion of these follows.

a) Strengths

Mann House clearly offered a number of very positive attributes. These included:

- Provision of a safe, protective, sensitive environment catering to the special needs of women with chemical dependencies and needing extended care.
- Advocating for women with chemical dependencies and promoting service development.
- Increasing public awareness of the needs of chemically dependent women through pamphlets, videos, presentations, conferences and other means.
- All female staffing raised the comfort level of some referring agencies.
- Sponsoring projects to increase the information base of women's needs (e.g. "Nine to Five", "Where do the Children Go".)
- Developing linkages with a number of community agencies such as the Rape Crisis Centre and Richmond House to improve service to clients.
- Flexibility in responding to the needs of women with duo-dependencies or other special needs.
- Involvement of a community-based board of directors encouraged exploration of new ideas and approaches.

During the course of our study we heard from several women who attributed their recovery to the staff and programmes of Mann House. These women all had very difficult recoveries and had typically "been through the system" several times prior to entering Mann House.

b) Weaknesses

Criticisms made of Mann House include:

- Frequent staff turnover and lack of consistency in staff training and skills resulted in inconsistent programming, some of which was considered to be out-of-step and counter-productive to the philosophy and programmes of Addiction Services. Concern was expressed that at times clients were offered psychotherapy too early, resulting in relapse.
- Staff of QCAS indicated that while female rehabilitation clients were all exposed to Mann House, few chose to seek admission there. Feedback from these people suggested that discipline and structure were lacking at Mann House.

- Inconsistent application of policies and procedures resulted in difficulties for both agencies. For example, we were advised that Mann House admitted some residents without adequate detoxification and that some residents continued to use substances while living there.

- Several sources external to Mann House indicated they believed Mann House did not support AA. However, board, staff and former residents of Mann House assured us this was not the case and that mandatory attendance at AA was integral to the Mann House programme.

4. Utilization and financing were ongoing issues

Exhibits VI-12 and VI-13 provide cost comparisons for the three male halfway houses and Mann House, and utilization information for Mann House.

Acknowledging inconsistencies in the available data, the indicators profiled point out widely varying lengths of stay and costs between the three Addiction Services facilities and Mann House. We suspect this is related to a combination of circumstances including the complexity of the needs of women treated at Mann House. In addition, we are uncertain of the extent to which the costs shown for the three male halfway houses reflect true costs. As they are part of the county services, some administrative costs may not be reflected or, if they are, economies of scale would reduce that component compared to the freestanding nature of Mann House.

From May 1986 until it closed in 1990, Mann House admitted 108 clients. Occupancy rates varied from year to year, but after a good beginning were below economic levels. While the programme was never formally evaluated, the 42% sober status rate compares favorably with the statistics of the QCAS Aftercare Study (Exhibit VI-13).

Exhibit VI-12
Extended care/halfway house facilities - cost profile—1989/90

	Talbot House Queens County	Georgetown House Kings County	St. Eleanor's House Prince County	Mann House
Annual cost	$201,726[1]	$76,265[1]	$129,520[1]	$187,220[2]
Cost/bed	$11,207	$7,627	$10,793	$18,722
Cost/admission	$1,801	$1,774	$1,245	$8,510
Cost/client day	$39	$45	$33	$82

[1] *Source: 1988/89 Public Accounts of Prince Edward Island (Short Term Care) adjusted upwards by 3% to reflect 1989/90 costs comparable to Mann House*

[2] *Mann House unaudited statement of revenue and expenditure for the year ended January 31, 1990.*

Exhibit VI-13
Mann House utilization statistics

	May-Dec 1986	1987	1988	1989	Jan-Oct 1990	Total	%
First Admission	21	19	14	18	13	85	79%
Subsequent Admissions	1	7	6	4	5	23	21%
Total Admissions	22	26	20	22	18	108	100%
Referral source							
Queens Co. Addict. Services	15	13	5	6	4	43	40%
Prince Co. Addict. Services	4	4	3	3	4	18	17%
Kings Co. Addict. Services	1	3	2	1	0	7	6%
Self	1	4	4	6	4	19	18%
Out of Province	0	0	0	0	4	4	4%
Other	1	2	6	6	2	17	16%
							100%
Drug of Choice							
Alcohol	10	16	13	11	10	60	56%
Alcohol and others	11	10	2	1	1	25	23.%
Other	1	0	5	10	7	23	21%
							100%
ALOS (all residents)	78	55	73	102	45		
ALOS (Programme complete)	121	85	148	159	74		
Occupancy Rate	85.8%	49.0%	36.3%	62.2%	34.3%		
Conditions of Discharge							
Completed Treatment	11	9	7	11	6	44	41%
Transfer, D/C, other	1	5	0	2	5	13	12%
Left Against Advice	10	12	13	9	7	51	47%
							100%
Referral To:							
AA (and others)	13	14	7	14	11	59	55%
WFS (and others)	1	1	1	0	1	4	4%
Other	0	1	0	0	0	1	1%
N/A	7	9	12	8	6	42	39%
Detox	1	1	0	0	0	2	2%
							100%
Present Status							
Sober	9	10	7	13	6	45	42%
Still Has Problems	5	6	3	5	5	24	22%
Unknown	8	10	9	4	7	38	35%
Deceased	0	0	1	0	0	1	1%
							100.0%

Statistics provided by Sister Anne Gillis, Mann House.

5. But the continuum did not work

As discussed in Chapter III, delivering quality services economically requires provision of a continuum of care in which all service providers cooperate to meet the needs of each individual. For whatever reasons, the rocky relationships between addiction services and Mann House resulted in the lack of a continuum of care. Over the years, various attempts were made to improve relationships between Mann House and the County Boards. While some improvements were made with the two outlying counties, relationships remained strained with QCAS. Each agency indicated a wide variety of concerns about the other, that evidently could not be resolved to the satisfaction of both. Since QCAS was the largest source of potential clients for Mann House, lack of resolution of this issue resulted in financial difficulties for Mann House. Questions of cost per resident and financial viability were then raised by government.

6. We do not support reopening Mann House as a private facility with government funding

Given the concerns about inconsistency of service provision, high cost and lack of cooperation between service providers, we believe government's only choice was to insist on incorporating Mann House under Addiction Services as a condition of receiving funding. To ensure continuity it was essential that Mann House be brought under the jurisdiction of one of the county agencies. As it was located in Queens County, QCAS was the obvious choice. However, the two parties were unable to reach agreement on how this would occur. As a result, Mann House closed in late 1990.

Mann House provided a valuable service to the women of PEI. It demonstrated the need for an extended care facility for chemically dependent women and facilitated the recovery of several women. It raised public awareness of the anguish and the needs of women resulting from substance abuse. The dedication of its board and staff must be acknowledged.

But we do not recommend the reopening of Mann House. The needs of women cannot be met by service providers at odds with one another. Government cannot afford to fund services not deemed to be cost effective. We therefore believe the solution to be in improving the services for women provided by the three county agencies. This will facilitate enhanced programming and improve access to services for women throughout the province. Our recommendations are contained in the following chapter.

E. Other services support women with chemical dependencies

In the previous sections we discussed the addiction services available on PEI. Before moving on to recommendations, however, in this section we identify some of the related services available to women with chemical dependencies.

1. Social services supports child care.

The Child and Family Service Division offers a substantial range of services available to women in need of treatment for chemical dependency. Self, family and agency referrals will be assessed by Division staff. Most persons referred qualify for financial assistance. A wide range of options for child care during treatment include in-home babysitting and foster care, as well as the main source of care - care by a family member, are supported by this Division.

2. Richmond Centre offers counselling services.

Staffed by social workers, psychologists and nurses, Richmond Centre provides crisis intervention, assessment and short-term therapy. Referrals come from physicians, community agencies and related services. Family and self referrals are also accepted. Approximately 60% of the patient load seen at Richmond Centre is female. Patients with addiction problems are referred for assessment to QCAS.

3. The Rape Crisis Centre provides counselling for victims of sexual abuse.

The Rape Crisis Centre provides both group and individual therapy for victims of sexual abuse. The majority of clients are women. Approximately 50% of the caseload have chemical dependencies and another 25% have direct involvement in the dependency of a parent or spouse. Agency and self-referrals are accepted.

4. Psychiatric inpatient units also accommodate patients with dependencies.

Active treatment hospitals in Charlottetown and Summerside provide inpatient beds for patients with psychiatric disorders. A portion of these patients also suffer from a chemical dependency.

5. Alcoholics Anonymous (AA) is an Island-wide self-help network.

All addictions services personnel indicated AA to be a vital element in the recovery process. Groups are in place throughout the Island and strong emphasis is placed throughout all stages of addiction treatment of the value of regular participation in AA. Family support groups such as Alateen and Al-Anon are also in place. In addition to AA, a Women For Sobriety group meets in the Charlottetown area.

6. Other agencies offer assistance.

A number of other agencies including the clergy, Catholic Family Services bureau and others also provide support and counselling to persons with chemical dependencies.

VII

Addiction Services For Women—Issues And Recommendations

In this chapter, we summarize our observations on addiction services for women on Prince Edward Island. Drawing on current literature, our review of addiction services in other provinces, and discussions with a broad range of key informants on PEI, we have identified several issues and developed a number of recommendations for addressing identified weaknesses. Those recommendations should assist PEI to move forward within the framework of a broader base as discussed in Chapters III and IV. Although many of the issues we identified are common to both men and women, our observations and recommendations focus primarily on services to women.

The base of treatment for alcohol problems on PEI needs to be broadened. Throughout the identification, assessment, treatment and aftercare phases, improvement in comprehensiveness and flexibility of programme delivery to meet individual needs is required. A wide range of professionals must become comfortable with identifying alcohol problems and be equipped with assessment tools that permit them to refer appropriately to treatment services. A spectrum of interventions that matches the spectrum of problems should be available. Addiction Services counselling staff must be well equipped to identify individual needs and to provide appropriate case management. And the public at large must be helped to develop more healthy attitudes toward women with alcohol problems.

Underlying the discussion and recommendations contained in this chapter, must be the recognition that funds for addiction services are limited. In the current fiscal climate it is unrealistic to expect governments to expand social programmes. Therefore, our recommendations should be considered as a framework to guide further development, within the resources available.

A. Staffing

By far the most important component of effective programmes is a very well-qualified staff in appropriate numbers. This section addresses specific recommendations relative to staffing of Addiction Services of PEI.

1. Staff education and gender mix should be addressed.

The development of a "broader base" of early identification and treatment of dependency problems requires enhanced training of health care and other professionals in the community and in the addiction field. These providers require

information on the indications for "brief intervention" and referrals for specialized treatment when necessary.

a) Recovering and non-recovering, professional and lay counselling staff are required.

At the present time, almost all the staff of Addiction Services are recovering persons. A few of these are among the professional group. Although the role of recovering persons in the counselling process is well recognized, their skills and experience should be supplemented with some professionally trained and clinically oriented counsellors. A mix closer to 50-50 should be a future staffing goal. This should facilitate enhanced responsiveness to the varied needs of women in treatment.

b) Staff education and breadth of knowledge are important.

Counsellors in all the programmes of Addiction Services should be trained to perform comprehensive assessments and to recognize both verbal and non-verbal cues of sensitive issues (physical or sexual abuse) underlying the primary addiction concern. Staff should recognize their limitations in providing counselling in these situations and should be sufficiently familiar with the professional counselling community to make appropriate referrals when necessary. To ensure that appropriate referrals are made, Addiction Services should develop a comprehensive inventory of counselling, therapy and community support services available. To the extent possible, the particular needs and belief systems of the client should be matched with those of the therapist or counselling service.

c) Each county agency should employ at least one female counsellor with special training in treating chemically dependent women.

Currently, the detox staff are female nurses. They do fulfill a counselling role to some degree but, as one client put it, "I didn't really feel comfortable going to her as she was too busy in detoxification. Counselling wasn't her job." Therefore, one female counsellor in each county should be specially trained to deal with the particular needs of women. This does not mean that all female clients would be directed to the female counsellor. But, based on the needs assessment, those expected to do better with a female counsellor would be directed her way.

In addition to carrying her own caseload, the female counsellor would provide ongoing education to all staff relative to the special needs of women. For those women with special needs, she would ensure appropriate assessment and referral.

d) Central office should develop staffing guidelines.

The preponderance of persons on the staff who have recovered from chemical dependency through Addiction Services has contributed to a relatively narrow view of the services which constitute optimal treatment. Attracting staff with

alternative experiences in training and/or recovery is consistent with our recommendation that you broaden your philosophical approach to treatment. Central office, in conjunction with county agencies, should formulate guidelines concerning:

- Minimum educational qualifications.
- Staff mix of professional/recovering.
- Minimum period of sobriety before hiring.
- Special skills for special needs (i.e. women, youth, duo-dependencies).
- Continuing education.

e) **Support systems for staff are required.**

Recognizing the unique stresses and vulnerabilities of the treatment and counselling staff, the boards should implement an Employee Assistance Programme (EAP).

We recognize that many of these recommendations will not be achieved overnight. Many of the staffing recommendations will require funds to upgrade existing staff. Others will not be achievable until staff turnover occurs through attrition.

B. Membership of the Provincial Advisory Committee should be broadened

The Provincial Advisory Committee was created in 1979. Its mandate is to provide advice to the minister on matters of overall policy, priorities and direction on addiction services. This committee is a valuable vehicle for providing the minister with input on addiction services.

However, we believe this committee would be more effective if it included broader representation. In particular, someone knowledgeable in the special needs of chemically dependent women should be included. We recognize this change may require revisions to existing regulations.

C. Quality and outcome monitoring should be further developed

1. Quality assurance must be built into the programmes of all three county agencies.

The need for quality assurance in all programmes of Addiction Services cannot be over-emphasized. Record and documentation audits should be performed regularly, perhaps using a peer review methodology with personnel from the other county agencies.

In addition, all clients leaving any of the programmes of Addiction Services should be surveyed to determine their satisfaction with programme content, methods, staffing and facilities. Board members and staff must be receptive to both positive and negative feedback from clients, using both to improve the quality of the service provided.

Actual involvement of patients in specific therapeutic activities should be monitored during treatment. Internal review activities including chart audits and case conferencing should be ongoing.

The drop-out rate from all programmes should be monitored and recorded by reason for programme termination, where possible. Goals to reduce drop-out rates and improve outcomes should be established and re-evaluated annually. And specific goals should be established for female participation in each programme.

Although each county is responsible for its own quality assurance, overall direction should be undertaken by the Central Office. In co-operation with each county agency, Central Office should develop standards of care and criteria for monitoring outcomes.

2. Programme evaluation is essential for both new and ongoing programmes.

Programme planning, monitoring and evaluation should be further developed.

The Provincial Director should ensure that consistent, timely and accurate data is collected from all three agencies. Data should include at least referral source, chemicals of choice, client demographics, programme utilization and status at separation. It should include mechanisms to provide feedback on job performance and family function as well as abstinence in order to more effectively evaluate outcome. This information should be analyzed regularly by the Central Office and used by the provincial director and the County agencies to assess activities and outcomes.

In addition, an independent external review of the programmes of Addiction Services should be conducted periodically, but at least every five years. These

evaluations would review programme rationale, activity and outcome through an assessment of operational efficiency, programme effectiveness and unmet need.

New programmes of Addiction Services should be subject to local board approval and begun as pilot projects. Decisions on programme continuation beyond the initial pilot phase should require a completed and successful evaluation of programme content, activities, utilization and outcomes.

D. Public education must continue

The Central Office should ensure that the community development and public education functions in each of the county agencies are operating in a coordinated fashion and are delivering appropriate and effective programmes and services. In general terms, you should be "teaching the teachers" and facilitating development of peer self-help groups in order to make the best use of scarce resources.

E. Addiction Services should assist other providers to recognize and refer persons with chemical dependencies

Research indicates that between twenty and thirty percent of patients in general hospitals have alcohol or drug problems related to their medical diagnosis. The hypertension, gastritis, depression, or injury which brings them to hospital is directly related to their alcohol or drug use. Yet, four out of five of these patients go home with this underlying problem still undetected. These men, women, young people and perhaps children suffer from medical, social and emotional problems related to their drug or alcohol abuse long before detection by "the health care system".

Addiction Services personnel are the specialists in treating the disease of addiction. But to be effective, these specialists must maintain effective working relationships with a wide range of providers. This is even more critical when focusing on prevention and early diagnosis and treatment.

Research has shown that brief advice does make a significant impact on alcohol use of early stage problem drinkers.

As discussed in Chapter III, the key to improving early identification and referral is in training other providers—physicians, social workers, nurses and others to recognize problems. This includes providing them with tools and knowledge as well as effective referral linkages. These providers need to be offered assistance when they see persons with problems, but cannot convince them to seek help.

Some easy-to-use screening tools for early identification have been developed. These can be used by a wide range of health care providers and social service. We recommend you explore use of these.

F. Programmes and services should meet women's needs

1. Early identification and treatment of chemical dependency is critical.

Traditional addiction services emphasize assessment and treatment for clients at the substantial to severe end of the continuum of need for service. While these needs are immediate and significant, accumulating evidence suggests that intervention in cases of mild or moderate addiction is much more effective in reducing addiction problems in the population at large (refer to Chapter III).

Addiction Services should continue to develop programmes and services aimed at primary prevention, education, case finding and brief intervention. Although early intervention does not replace the need for specialized addiction treatment centres, it broadens the base of service by directing efforts at the mild and moderate problems which are now going largely undetected.

2. Flexibility to accommodate unique needs will improve effectiveness.

Utilization statistics included in Chapter VI confirm that women on PEI use services provided through Addiction Services treatment programmes much less than men. And female utilization has been declining. Although the reasons for this are undoubtedly many and varied, one might question the extent to which the programmes now offered are actually meeting women's needs. In other Atlantic Provinces, where specific women's programmes are in place, female utilization is improving. The reduction in female utilization of the various programmes on PEI should be investigated.

Effectiveness of services and programmes is largely dependent on their flexibility. Programmes must address the individual and varied needs of clients, rather than forcing clients with complex needs to comply with a rigidly structured and uniformly delivered programme. Programme content should be balanced between didactic, group therapy and individual counselling components. Our specific recommendations regarding flexibility follow.

a) Addiction Services should offer a women's non-residential or day/evening rehabilitation programme.

Because of the very real family-related obligations of many women requiring treatment, residential rehabilitation is not always a viable option. An out-patient day programme running four days or evenings per week and lasting five to six weeks should be piloted, perhaps in Queens County. This should be a comprehensive programme running full days (say 9:00 a.m. to 3:00 p.m. or 5:30 p.m. to 10:00 p.m. to coincide with school hours, or others most suitable to client needs) and should include the elements discussed in Chapter IV. Provision of optional child-care either on or off-site would enhance the programme's flexibility and attractiveness for some female clients.

b) **Addiction Services should offer a women's residential rehabilitation programme if the day programme cannot meet all needs for general segregated programming.**

Programmes for residential rehabilitation now exist in Queens and Prince Counties. However, there are no gender separate programmes or residential facilities physically separated from the detoxification units. As a general principle, residential rehabilitation facilities should be physically separate from detoxification facilities.

If the day programme is successful, we anticipate the demand for residential rehabilitation will be too small to warrant separate programmes, facilities and staffing for women. Residential programmes could be offered by accommodating women in the same physical setting as now, or in a facility such as Lacey Residence, if available, but attending the day programme.

c) **Lacey Residence should be supported by Addiction Services as a valuable component of the continuum of care for chemically dependent women.**

Lacey Residence, operating under the auspices of ADPI, is now filling the need for an extended care residential facility for chemically dependent women. Although the facility has only been operating for a short while, many providers and referral agents on the Island are optimistic it will succeed.

As of our latest visit, Lacey Residence was fully occupied. Lacey Residence is providing a protective, supportive environment that is structured yet responds to individual needs. Residents may receive visits from their children and participate in their care as appropriate. Since Lacey Residence is the only facility on the Island, it must be able to respond to the needs of women of all ages, and with diverse histories of chemical dependency. It will therefore be important to continue to maintain openness to individual needs, and to pursue individual goal setting.

As Lacey Residence develops, it is essential that it be integrated with the community. A wealth of resources including counselling in sexual abuse, mental health services, parenting skills, job skills and others exist in Charlottetown. These agencies should form part of the continuum of care not only as part of the referral process, but also for staff education. It is also essential that the effectiveness of Lacey Residence be independently evaluated. We recommend this occur after two years of operation.

d) **Addiction Services should provide separate women's aftercare, outpatient and support groups.**

i) **Aftercare should be flexible and responsive to individual needs.** The key to provision of effective aftercare services to women is flexibility—flexibility of form, content and timing. Once the detoxification and rehabilitation programmes are completed, ongoing sobriety depends on adherence to the behavioural and lifestyle changes learned. As clients again encounter the pressures of their everyday lives, aftercare must continue. Programmes providing these services will be successful only to the extent that

they can attract and keep their clients attending sessions. To a large extent, the commitment and attendance of clients in aftercare depends on the relevance of the programme's content, the manner in which the content is presented, and accessibility in terms of timing and location.

On PEI, aftercare consists of weekly attendance at one group meeting led by an aftercare counsellor and at least one or two meetings of Alcoholics Anonymous or another self-help group. Individual counselling, for clients who require it, is also an important part of aftercare. Generally, clients are encouraged to remain in aftercare for at least six months. All groups have been integrated, but some all-female groups are now being tried.

The need for participation in groups of recovering persons should be considered along with the individual client's need for personal counselling. A balance of educational sessions, group therapy and individual counselling should be tailored to meet the needs of individual clients. The aftercare mechanisms most likely to result in the best outcome for the client should, if possible, be made available. Clients should be offered a range of options for aftercare in terms of timing, frequency of meetings, availability of adjunct child-care, etc. As well, individuals should be offered the option of gender integrated or gender separate groups. Aftercare counsellors should be trained to recognize the special problems of women and to offer guidance in choosing the format of aftercare appropriate to each individual.

ii) **Support for effective self-help groups is critical.** The effectiveness of attendance at Alcoholics Anonymous as an essential part of aftercare for many persons is well recognized. Indeed, for some, it stands alone as a means of gaining and maintaining sobriety. However, for the following reasons, we believe that additional options for mutual support groups should be made available.

- We understand that some AA groups are not supportive of the individual needs of persons requiring mood altering medications for psychiatric disorders such as manic depression or schizophrenia.

- Some women, particularly the substantial number who have been victims of violence, have expressed discomfort with sharing their experiences in the company of men.

- Other women prefer alternatives to the twelve step programming of AA.

Mixed gender AA meetings should not be the only option for women seeking mutual support during their recovery from chemical dependency. If AA alone cannot meet the needs of women recovering from addictions, we suggest that Addiction Services facilitate the establishment of independent self-help groups. All-women's AA groups and other groups to supplement AA have been tried successfully in other provinces.

iii) **Individual counselling is an important component of effective aftercare.** One-on-one counselling is an essential component of aftercare. Personal counselling should explore the effectiveness of other aftercare services and facilitate resolution of difficulties. Counselling should also facilitate referral to other needed services.

Addiction Services counsellors should continue periodic contact with clients, even after referral to other agencies or support groups. Counsellors should encourage clients leaving aftercare to return if the referral is unsatisfactory or if the addiction problem reoccurs.

As clients are identified and recognize their need for assistance and support at earlier stages, outpatient counselling should be available not only as a mechanism for aftercare, but for clients requiring support in coping with their problem from a preventive perspective.

3. Community outreach and support will benefit women all along the "continuum of need".

One community worker in Tignish provides outreach, case-finding and referral services in the local area. This model, used successfully in other provinces, allows the addiction services agency to be more sensitive and responsive to the particular needs of individuals in the community. The role of community workers should include problem recognition, assessment, family and client support, outreach and public education. At least one should be included in the staff of each county agency.

4. Addiction Services should enhance linkages to community agencies.

Depending on the particular needs of women, counsellors should provide a referral channel to other agencies such as rape crisis centres, mental health services, social services, employment centres, child care facilities, housing agencies and churches. It is essential that counsellors are well informed about community resources in these and other areas such as continuing education, music, relaxation therapy, yoga, aerobics and meditation.

5. Addictions Services should undertake a child care needs assessment for women seeking treatment at any stage of the process.

Many, but by no means all, women in need of treatment have child care responsibilities. Some of these women will have family members willing and able to care for their children when they need treatment. Others will not. Women who qualify for social assistance may benefit from a range of child care options available through Child and Family Services. Others may be required to finance such services privately.

Staff of Addictions Services were divided on the issue of child care. While some indicated the lack of child care had not been a barrier to anyone genuinely seeking treatment, others disagreed. And the vast majority of "external" informants believe child care to be a barrier to treatment for many women.

In our view, the barrier is in the perception rather than the reality. This suggests a need not for more services per se, but rather for providing accurate information to the public. However, it also requires a needs evaluation. The studies previously done under Mann House jurisdiction lacked credibility with a number of key agencies.

The care delivery system must recognize the child care needs of women. It must also demonstrate its support for women seeking treatment. We recommend that a multi-agency group involving addiction services, child and family services, Advisory Council on the Status of Women, day care licensing and other key agencies undertake a study to determine child care requirements for women with chemical dependencies. This study should be completed within one year.

6. Physical facilities for women's programmes should be improved as resources permit.

Addiction Services personnel recognize the following inadequacies in their respective facilities:

- Lack of private facilities (eg. bathing) for women.
- Lack of separation of detoxification and rehabilitation clients.
- Lack of recreational facilities.

None of the facilities now in use was originally designed to house an addiction treatment facility. Further, none were developed with the particular needs of women in mind. It is therefore not surprising that these facilities have limitations.

The optimal solution would be to replace each of the existing facilities with a functionally designed facility that includes separate areas for men and women, and separate detoxification and rehabilitation areas. However, given the unit sizes, this solution is unlikely to be affordable. We suggest a phased approach to upgrading the facilities in each county with a particular emphasis on improving privacy for

women. In view of the small numbers, we expect support services will need to continue to be combined for women and men, and for detoxification and rehabilitation. Also, we expect your current level of reliance on inpatient services will in time, be reduced. We expect future programme growth to occur in outpatient services. In time, it may be possible to convert some bed space to other functions.

7. Future directions should enhance outpatient programmes.

As discussed in Chapter VI, PEI relies much more heavily on inpatient beds than other Atlantic provinces. Inpatient care is not only more expensive, but many agencies report better outcomes, particularly for women, with outpatient programmes.

We therefore recommend that you focus on strengthening outpatient programmes and that you examine very carefully how many inpatient beds are required. We believe you may find opportunities to fund some outpatient programme enhancements by reducing the volume of inpatient services over time.

G. Summary

Our key recommendations are summarized as follows.

Given the population and resources of the Province of PEI it is essential that all providers of addiction services to women work together to provide an effective, efficient continuum of care. This system must be flexible and responsive to the individual and special needs of women. It must offer coordinated services that are all aimed at the common goal of achieving long term sobriety. To achieve this goal a number of specific initiatives are needed. These include:

- Enhance staffing in addiction services to include more female counsellors, more professionally trained counsellors, and counsellors specifically trained to recognize and deal with the special needs of women.
- Develop a pilot non-residential comprehensive rehabilitation programme for women.
- Provide separate women's aftercare groups.
- Enhance linkages between Addiction Services and related community agencies for the purposes of staff education, client programme delivery and earlier identification.
- Appoint a multi-agency task force to explore, in detail, the child care needs of women in need of treatment for chemical dependency.
- Develop formal quality assurance programmes within each County agency.

- Develop formalized programme planning and evaluation of all addiction services.

- Broaden the membership of the Provincial Advisory Committee to include an individual with knowledge of the special needs of women with chemical dependencies.

To ensure a cost effective continuum of care, we do not recommend that government reinstate funding for Mann House. Continuing many of the Mann House programmes through the existing County agencies and redirecting the funds from Mann House to these agencies will provide the most cost effective treatment system. Achieving a comprehensive and effective continuum of care will demand ongoing commitment to staff development and creation of more flexible arrangements to meet the needs of chemically dependent women on PEI.

Appendices

Appendix A - Footnotes

Footnotes

Institute of Medicine, Broadening The Base of Treatment for Alcohol Problems, (Washington: National Academy Press, 1990), p. 211.

Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems, p. 212, citing Skinner, H.A., Executive Summary: Spectrum of drinkers and Intervention Responses. Prepared for the I0M Committee for the Study of Treatment and Rehabilitation Services For Alcoholism and Alcohol Abuse.

Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems, p. 211-213.

Ibid., p. 215.

Ibid., p. 218.

Ibid., p. 46.

Ibid., p. 218-219.

Beth Reed, "Developing Women-sensitive Drug Dependence Treatment Services: Why So Difficult?", Journal of Psychoactive Drugs 19(2) (Apr-Jun 1987): p. 160.

Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems, p. 225 citing Sanchez-Craig, M., Executive Summary: Secondary Prevention of Alcohol Problems By Brief Intervention. Prepared for the I0M Committee for the study of Treatment and Rehabilitation Services for Alcoholism and Alcohol Abuse

Ibid., p. 225

Ibid., p. 225

Ibid., p. 225

Ibid., p. 65-66

Ibid., p. 72-73

Reed, "Developing Women-sensitive Drug Dependence Treatment Services: Why So Difficult?", p. 155.

Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems, p. 14 citing Maxwell, MA. 1950 The Washington Movement. Quarterly Journal of Studies on Alcohol 11:410-451.

Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems, p. 14.

Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems, p. 80.

Ibid., p. 357.

The Women's Alcoholism Program of CASPAR, Getting Sober, Getting Well: A Treatment Guide For Caregivers Who Work With Women, p. 177-179.

Reed, "Developing Women-sensitive Drug Dependence Treatment Services: Why So Difficult?" p. 161.

Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems, p.403.

Ibid.

Reed, "Developing Women-sensitive Drug Dependence Treatment Services: Why So Difficult?" p. 161.

Ibid., p. 157.

Ibid.

Ibid.

The Women's Alcoholism Program of CASPAR, Getting Sober, Getting Well, p.165.

Institute of Medicine, Broadening the Base of Treatment for Alcoholism Problems, p.245.

Appendix B - List Of Organizations Interviewed

Agencies And Individuals Interviewed

Staff, former staff, clients and Board members of:

- Queens County Addiction Services
- Prince County Addiction Services
- Kings County Addiction Services
- Mann House

Staff of:

- Richmond Centre
- Advisory Council on the Status of Women
- Rape Crisis Centre
- Anderson House

Provincial government departments and divisions:

- Minister and Deputy Minister, Health and Social Services
- Director of Mental Health
- Child & Family Services
- Child Care Division
- Addiction Services

Other:

- Family physicians and psychiatrists